DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 96-35

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 1996 & October 1, 1996

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 1995-1996 $-4.55m
b. FFY 1996-1997 $-18.225m

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4,19-A Part I Pages 117(a),117(a-1), 117(b),117(c),226(a),250
*** SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A Part I Pages 117(a), 117(b),117(c),226(a)

No Previous Pages: Attachment 4.19-A Part I Pages 117(a-1),250

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☒ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Brian J. Wing

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:
September 30, 1996

16. RETURN TO:
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243

17. DATE RECEIVED:

18. EFFECTIVE DATE OF APPROVED MATERIAL:
07/01/96 & 08/01/96

19. [illegible]

20. [illegible]

21. TYPED NAME:
Sue Kelly

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS: As per State letter dated 01/04/99, the effective dates have been changed to the following: 07/01/96 & 08/01/96. Revised pages were also submitted and approved to replace Attachment 4.19-A Part I Page 117(a). Originally submitted pages 117(a-1), 117(b), 117(c), 226(a) and 250 were not approved.

FORM HCFA-179 (07-92)

Instructions on Back

(d) For rates of payment for discharges in 1991 and thereafter, a general hospital having less than 201 certified acute non-exempt inpatient beds that is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by federal law (see 42 U.S.C. section 1395 ww(d)(2)(D)) or defined as a rural hospital under state law may choose to have its DRG specific operating cost component be 100 percent of the hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54(a) of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart, provided however, commencing April 1, 1996 through July 31, 1996 the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group shall be reduced by five percent and commencing August 1, 1996 through March 31, 1997 the reimbursable inpatient operating cost component of case based rates of payment per diagnosis-related group shall be reduced by two and five-tenths percent to encourage improved productivity and efficiency. In order to exercise this option for 1991 or subsequent rate years, the general hospital shall notify the Department of such election in writing by no later than December first of the preceding rate year or a later date as determined by the Commissioner.

(e) For discharges on or after April 1, 1995 and prior to April 1, 1996, the DRG case-based rates of payment for patients assigned to one of the twenty most common diagnosis-related groups, will be held to the lower of the facility specific amount or the average amount, as determined pursuant to subdivision (c) of this section for all hospitals assigned to the same peer group. The twenty most common diagnosis-related groups shall be determined using discharge data two years prior to the rate year, but excluding beneficiaries of title XVIII (Medicare) of the federal social security act and patients assigned to diagnosis-related groups for human immunodeficiency virus (HIV) infection, acquired immune deficiency syndrome, alcohol/drug use or alcohol/drug induced organic mental disorders, and exempt unit or exempt hospital patients.

(f) Effective July 1, 1995 through June 30, 1996, rates of payment for inpatient acute care services shall be reduced by the Commissioner to reflect the elimination of operational requirements previously mandated by law, regulation promulgated in accordance with applicable standards and procedures for promulgating hospital operating standards, the Commissioner, or other governmental agency as follows:

(i) An aggregate reduction shall be calculated for each hospital based upon: the result of eighty-nine million dollars annually for 1995 and trended to the rate year, multiplied by a ratio based upon data two years prior to the rate year, consisting of hospital-specific case-based Medicaid patient days divided by total case-based Medicaid patient days summed for all hospitals.

(ii) the result of the hospital specific amount allocated to exempt units shall be based upon the ratio of hospital specific exempt unit Medicaid patient days to hospital specific total Medicaid patient days of which the result is divided by the hospital specific exempt unit Medicaid patient days to produce a

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unit of service reduction in the per diem rates of payment.

(iii) any amount not allocated to exempt units shall be divided by case based discharges consisting of data two years prior to the rate year resulting in a per case unit of service reduction for payment rates.

(g) For discharges [~~on or after~~] for the period April 1, 1996 through July 31, 1996 the DRG case-based rates of payment shall be the sum of:

(1) an amount, determined pursuant to subdivision (c) of this section, excluding those costs for direct and indirect medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2) respectively, of this subpart;

(2) minus five percent of the amount determined in accordance with paragraph (1) of this subdivision to encourage improved productivity and efficiency;

(3) plus the value of direct medical education as determined pursuant to section 86-1.54(g) of this subpart;

(4) minus five percent of the costs of hospital based physicians reflected in the direct medical education amount determined pursuant to section 86-1.54(g) of this subpart;

(5) plus the value of forty-five percent of the indirect medical education expenses as determined pursuant to section 86-1.54(h)(1)(iv)-(v) of this subpart;

(6) plus the value of fifty-five percent of the indirect medical education expenses reflected in the hospital's peer group average inpatient operating cost per discharge determined pursuant to section 86-1.54(b) of this Subpart;

(h) For discharges for the period August 1, 1996 through March 31, 1997 the DRG case-based rates of payment shall be the sum of:

(1) an amount, determined pursuant to subdivision (c) of this section, excluding those costs for direct and indirect medical education as determined pursuant to sections 86-1.54(g), 86-1.54(h)(1)(iii) and 86-1.54(h)(2) respectively, of this subpart;

(2) minus two and five-tenths percent of the amount determined in accordance with paragraph (1) of this subdivision;

(3) plus the value of direct medical education as determined pursuant to section 86-1.54(g) of this subpart;

(4) minus two and five-tenths percent of the costs of hospital based physicians reflected in the direct medical

education amount determined pursuant to section 86-1.54(g) of this subpart;

(5) plus the value of forty-five percent of the indirect medical education expenses as determined pursuant to section 86-1.54(h)(1)(iv)-(v) of this subpart;

(6) plus the value of fifty-five percent of the indirect medical education expenses reflected in the hospital's peer group average inpatient operating cost per discharge determined pursuant to section 86-1.54(b) of this Subpart;

(i) ~~(h)~~ Effective July 1, 1996 through March 31, 1997, rates of payment for inpatient acute care services shall be reduced by the Commissioner to encourage improved productivity and efficiency by a factor determined as follows:

(1) An aggregate reduction shall be calculated for each hospital based on: the result of eighty-nine million dollars annually for 1996, multiplied by the ratio of hospital-specific case based Medicaid patient days, in a base year two years prior to the rate year, consisting of hospital-specific case-based Medicaid patient days divided by the total of such patient days summed for all hospitals.

(2) The result for each hospital shall be allocated to exempt units within such hospital based on the ratio of hospital specific exempt unit Medicaid patient days to hospital specific total Medicaid patient days of which the result is divided by the hospital specific exempt unit Medicaid patient days to produce a unit of service reduction in the per diem rates of payment.

(3) Any amount not allocated to exempt units shall be divided by case based discharges (or for exempt hospitals by patient days) in the base year two years prior to the rate year, resulting in a per case (or for exempt hospitals a per diem) unit of service reduction in payment rates.

(iii) A bad debt and charity care allowance, a health care services allowance and a financially distressed allowance as determined pursuant to the provisions of section 86-1.65 of this Subpart.

(d) Rates of Payment for Acute Care Children's Hospitals. Hospital services provided to non-Medicare patients in acute care children's hospitals shall be reimbursed on a diagnosis-related group basis composed of:

(1) 1994 reimbursable operating costs computed on the basis of the hospital's reimbursable operating costs as defined in paragraph (a)(4) of this section and statistical data for the same period. The base year Medicare share of these costs will be removed in accordance with paragraph (a)(%) of this section. The non-Medicare hospital operating costs shall be trended to the rate year pursuant to section 86-1.58 of this Subpart and further adjusted for changes in volume and case mix from the base to the rate year using total reimbursable non-Medicare costs and statistics of the hospital pursuant to section 86-1.64 of this Subpart. The DRG specific operating cost component shall be computed utilizing one-hundred percent hospital specific reimbursable costs with no adjustment for long stay or high cost outliers pursuant to section 86-1.54(f)(1) and (3) of this Subpart.

(2) The acute cost component computed on the basis of budgeted capital costs allocated to the inpatient portion of the hospital pursuant to the provisions of section 86-1.59 of this Subpart, divided by the budgeted discharges and shall be reconciled to total actual expenses and discharges;

(4) A health care services allowance of .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospitals' non-Medicare reimbursement inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(5) Discrete long stay and high cost outlier rates of payment shall not be paid.

(6) For rates of payment ~~on or after~~ for the period April 1, 1996 through July 31, 1996, the operating cost component of rates of payment for Acute Care Children's Hospitals as determined pursuant to this paragraph shall be reduced by 5%, and for the period August 1, 1996 through March 31, 1997 the operating cost component of rates of payment shall be reduced by 2.5% to encourage improved productivity and efficiency.

TN 96-36 Approval Date JUN 06 2001
Supersedes TN 96-26 Effective Date JUL 01 1996
AUG 01 1996

Attachment 4.19-A
Part I

Effective July 1, 1996, enhancements to the Medicaid reimbursement rates of three hospitals in the western part of New York State will be provided to enable them to study and analyze several issues pertaining to the care of patients who have multiple impairments or patterns of behavior that are manageable but potentially disruptive to the facility. Hospitals have been constrained in formulating discharge planning approaches which will promote appropriate placement of these individuals. The three hospitals, Strong Memorial Hospital (Rochester), Park Ridge Hospital (Rochester), and Soldiers & Sailors Hospital (Penn Yan), will conduct a demonstration in conjunction with their respective affiliated nursing facilities to address several patient care related issues, including but not limited to the following:

a) identifying the characteristics and unique care needs of the multiply impaired patients;

b) assessing the reasons why they are difficult to place from hospitals to community based settings including nursing facilities;

c) evaluating and determining "best treatment" regimens;

d) developing a training program to assist other hospitals in more effectively placing these patients in community based settings.

TN 96-36 Approval Date JUN 06 2001
Supersedes TN New Effective Date JUL 01 1996
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